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No. 91-1578

In The
Supreme Court of the United States
OCTOBER TERM, 1991

JANE TOMCZYK,

Petitioner,

v.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court of Appeals For the Seventh Circuit

BRIEF OF RESPONDENT IN OPPOSITION TO PETITION FOR CERTIORARI

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COUNTER STATEMENT OF THE QUESTION PRESENTED FOR REVIEW

1. Should the Courts grant and affirm a motion for summary judgment where the pleadings and other documents of record in the case show that there are no material facts in dispute and that the moving party is entitled to judgment as a matter of law?

RULE 29.1 LIST

Blue Cross & Blue Shield United of Wisconsin (Blue Cross) has no parent company. It holds a controlling interest in the following companies which are not wholly-owned subsidiaries: United Wisconsin Services, Inc.

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BRIEF OF RESPONDENT IN OPPOSITION TO PETITION FOR CERTIORARI

The Respondent Blue Cross & Blue Shield United of Wisconsin (Blue Cross), by its undersigned counsel, respectfully requests this Court to deny the Petition for a writ of certiorari to the United States Court of Appeals for the Seventh Circuit for review of the judgment in *Tomczyk v. Blue Cross & Blue Shield United of Wisconsin*, Case No. 91-1018, December 30, 1991.

OPINIONS BELOW

The Petitioner seeks a writ of certiorari from an opinion of the United States Court of Appeals For The Seventh Circuit decided on December 30, 1991, *Tomczyk v. Blue Cross & Blue Shield United of Wisconsin, Case No. 91-1018,* which affirmed a Decision and Order of the United States District Court, Eastern District of Wisconsin, entered on May 8, 1989, *Tomczyk v. Blue Cross & Blue Shield United of Wisconsin,* 715 F. Supp. 914 (E.D. Wis. 1989).

COUNTER STATEMENT OF THE CASE

Contrary to the impression conveyed by the Petition, the opposing affidavits in this case upon which the District Court and Court of Appeals based their decisions granting and affirming summary judgment for Blue Cross are not in conflict, and the district and appellate courts below did not inappropriately shift any burdens to Petitioner in ruling on the motion for summary judgment. Moreover, controlling precedent clearly dictated dismissal of Tomczyk's claims for extracontractual damages.

Petitioner Tomczyk was a member of an ERISA regulated group health insurance plan issued by Blue Cross and sponsored by her employer. Tomczyk's insurance through Blue Cross was subject to the Blue Cross "Advantage Program." Under this program, certain requirements must be met before a plan member may receive full benefits for covered services for non-emergency inpatient hospital care. The member must notify Blue Cross prior to an admission that hospitalization is anticipated. Blue Cross

then determines whether the inpatient hospitalization is medically necessary, and authorizes the admission and a length of stay. The insurance contract provides that "[i]f the admission was not preauthorized, benefits will be limited to 80% of the amount otherwise allowed according to the contract provisions for covered benefits." The contract further states that even where the hospital stay is preauthorized, "[o]ther limitations, exclusions and conditions of the contract are not affected by this section and still apply."

Tomczyk first consulted with John Goeckermann, D.D.S., who subsequently performed surgery on her jaw, on September 21, 1987. Goeckermann determined that Tomczyk required corrective treatment consisting of two variations of an oral surgical procedure known as "osteotomy of the temporo mandibular joint." On September 30, 1987, an employee of Goeckermann's office called Blue Cross' Advantage Program and spoke to Elise McKinch, R.N., a Managed Care Specialist, who reviews the medical necessity of inpatient hospital admissions and authorizes lengths of stay.

McKinch determined whether the proposed services were most appropriately performed as inpatient, or whether they could be performed on an outpatient basis. McKinch informed Goeckermann's office that Blue Cross "would authorize a three day inpatient hospital stay" for Tomczyk. She also informed Goeckermann's office "that the authorization related to the patient's need to have the procedures done as an inpatient and was not an authorization of coverage." She also stated that "it would be advisable to get verification of coverage from Blue Cross' Medical

Review Department." Because she had determined, and informed Goeckermann's office, that the procedure might not be a covered benefit, she did not send the customary letter confirming preauthorization of the hospital stay.

On October 12, 1987, Blue Cross received a letter from Goeckermann dated October 7, seeking "prior determination of benefits for the proposed surgery." Blue Cross never indicated that the surgery was a covered benefit.

After undergoing the oral surgery in late October of 1987, Tomczyk filed a claim with Blue Cross for reimbursement of approximately $8,250 in medical expenses. Blue Cross denied the claim because the type of surgery performed was not a covered benefit of the plan. Tomczyk then sued Blue Cross under ERISA for denial of contract benefits and in addition, brought state common-law claims of bad faith, breach of contract, tortious interference with her contractual relationship with her doctor and asserted a constitutional claim under 42 U.S.C. § 1983. Blue Cross moved for summary dismissal of all claims.

The District Court dismissed the state common-law claims as preempted by ERISA, and the § 1983 claim owing to a lack of state action. In a separate decision granting Blue Cross summary judgment on the ERISA claim, the court determined that no genuine issue of material fact existed and found that Blue Cross had properly denied benefits to Tomczyk under the terms of the contract. Tomczyk appealed the grant of summary judgment to Blue Cross on the ERISA claim, and the dismissal of her state common law and extra-contractual damage claims.

In her appeal, Tomczyk did not dispute the District

Court's finding that her surgery was not covered under the insurance plan. Rather, she claimed that the court should not have granted summary judgment because there was a disputed factual issue concerning whether Blue Cross had verbally verified payment of her medical expenses.

The Court of Appeals, like the District Court, found no disputed issue of material fact in evidence, and affirmed the District Court's grant of summary judgment to Blue Cross on the ERISA claim. The Court of Appeals also affirmed the District Court's dismissal of Tomczyk's state common-law extracontractual damage claims.

In rendering its decision, the Court of Appeals found that "misrepresentations of controlling law and disingenuous arguments . . . were mainstays of Tomczyk's brief. . . . when the law disfavored Tomczyk's case it was ignored, glossed over, or misstated. Puffery was proffered as fact. Her attorneys presented the record in a thoroughly misleading and unprofessional fashion. . . demonstrating frivolousness." For these reasons, the Court of Appeals imposed sanctions upon Tomczyk's counsel pursuant to Rule 38 of the Federal Rules of Appellate Procedure.

REASONS FOR DENYING THE WRIT

I. The Petitioner Has Failed To Show Special And Important Reasons For Granting Certiorari.

> "Special and important reasons" for granting Supreme Court review "imply a reach to a problem beyond the academic or the episodic...[I]t is very important that we be consistent in not granting the writ of certiorari except in cases involving principles the settlement of which is of importance to the

public as distinguished from that of the parties."

Rice v. Sioux City Cemetery, 349 U.S. 70, 74, 79 (1955) (citations omitted).

Petitioner's true motivation for filing the Petition in this case can be summed up by a phrase quoted from the Petition itself; "Tomczyk, and her counsel . . . petition this court . . . with the hopeful restitution of their reputation." Pet. p. 8. A review of the Petition quickly reveals it is not based upon the merits of the case itself. Rather, it represents an effort on the part of Petitioner's counsel to restore his reputation in the legal community. Just like all of the briefs and oral arguments which have gone before by this law firm against this and other insurance company defendants, however, the Petition contains mischaracterizations and misstatements of the facts and law, and frivolous arguments which ignore controlling precedent. The Petition fails to demonstrate that any of the considerations of Rule 10 of the Supreme Court Rules governing Petitions for Certiorari are met.

A. The Record In This Case Supports The District Court's And Court Of Appeals' Independent Conclusions That No Material Facts Are In Dispute And That Summary Judgment Was Appropriate.

When a motion for summary judgment is made and supported by affidavits demonstrating a prima facie case for summary judgment, the non-moving party must, by affidavits or otherwise, set forth specific facts showing that there is a genuine issue for trial. Fed. R. Civ. P. 56 (c) and (e). To defeat a properly supported motion, the nonmoving party must produce sufficient evidence for a jury to return a verdict in his favor. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242,

249 (1986). Petitioner claims that her case was subjected to "trial by affidavit" and that "reasonable inferences" were resolved against her, contrary to the summary judgment standards. The record, however, demonstrates that such was not the case.

The evidence presented by Tomczyk to oppose Blue Cross' motion for summary judgment does not contradict and in fact confirms the account given by McKinch in an affidavit submitted by Blue Cross. Tomczyk presented an affidavit from Goeckermann, wherein he states that McKinch told his office that Blue Cross "had authorized the *hospital stay* for the intended surgery." (emphasis added). The McKinch affidavit also states that she informed Goeckermann's office on September 30, 1987 that Blue Cross had authorized the *hospital stay* for the intended surgery. Pet. App. 44 and 49. The McKinch and Goeckermann affidavits are in accord. Goeckermann's affidavit does not refute McKinch's account that she further informed his office that verification of benefits for the surgery itself must be obtained from Blue Cross' Medical Review Department. Pet. App. 44. In fact, Goeckermann's subsequent actions confirm McKinch's account in this regard, in that seven days later, Goeckermann sent a letter to Blue Cross "request[ing] a prior determination of benefits for . . . Tomczyk . . ." Pet. App. 46.

Petitioner argues that the court below violated the standards for summary judgment by not inferring from Goeckermann's affidavit and his October 7 letter that Blue Cross preauthorized *both* the hospital stay *and* verified benefits for the surgical procedure in the September 30 phone conversation with McKinch. Pet. pp. 10-11. This argument is truly a non-sequitur.

The affidavits are clear on their face and speak for themselves. Had Goeckermann intended to say that he believed benefits for the surgery itself had been verified, one must presume he would have used words that expressed that it was the "surgery" that was authorized, not the "hospital stay." Moreover, it is obvious that it would make no sense for Goeckermann to subsequently request a verification of benefits for Tomczyk's surgery if, as Petitioner contends, Goeckermann believed his office had already received such verification from McKinch on September 30.[1] The affidavits on file show no material issue of fact in dispute. There were no reasonable inferences to be drawn in Tomczyk's favor, and the Court of Appeals did not err by affirming the District Court's grant of summary judgment in favor of Blue Cross on Tomczyk's ERISA claim.

B. The District Court And Court Of Appeals Correctly Concluded That Petitioner's Claims For Extracontractual Damages, Including Her Claim Of Bad Faith, Are Preempted by Federal Law.

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[1] Petitioner attempts to muddy the issues by contending that the Court of Appeals erred in identifying the date of Tomczyk's surgery as October 3, rather than October 27, 1987. In any event, the date of the surgery is not a material fact. The material and still undisputed fact is that Goeckermann submitted the verification request regarding the surgery to Blue Cross *after* McKinch spoke with his office. The only reasonable inference to be drawn from this fact is that he did not believe benefits for the surgery had already been verified in the September 30 telephone conversation with McKinch.

Bad Faith Claim

Controlling precedent is clear: Tomczyk's state law claim for bad faith is preempted by ERISA. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 49-57 (1987), this Court held that Mississippi's state law tort of bad faith is preempted and not saved by ERISA. Relying on the analysis in *Pilot Life*, the Federal District Court for the Eastern District of Wisconsin ruled that the Wisconsin law of bad faith is preempted. *See Rust v. Blue Cross & Blue Shield United of Wisconsin, et al.*, 1988 U.S. Dist. LEXIS 17207 at 11-12 (E.D. Wis. Sept. 21, 1988). Res. App. 1, 9-10. Citing *Pilot Life*, the District Court in *Rust* held:

> In *Anderson v. Continental Insurance Company*, 85 Wis. 2d 675, 689, 271 N.W.2d 368, 375 (1978), the Wisconsin Supreme Court stated that "*every* contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." (Emphasis added.) Thus, since the Wisconsin tort applies to "every contract," not just insurance contracts, bad faith would not meet the requirements of the savings clause under either a common-sense understanding of the phrase "regulates insurance," *see* 107 S. Ct. at 1554, or under an examination of whether the tort is limited to the insurance industry. Furthermore, the tort of bad faith cannot be said to have an impact on the spreading of policyholder risk, nor is the tort an integral part of the relationship between insured and an insurer. *See Pilot Life*, at 1554-1555 (bad faith tort applies no differently to insurance contract than any other contract). In sum, the analysis of the Wisconsin bad faith tort is almost identical to that of the Supreme Court on Mississippi's bad faith tort. The conclusions certainly are: the Court finds the Wisconsin tort of bad faith is pre-empted by ERISA."

Id.

In affirming the dismissal of Tomczyk's bad faith claim, the Court of Appeals noted with grave concern the fact that in the appellate brief, her counsel failed to cite *Rust* and another controlling case on the question of preemption of other common law tort claims, *Meyer v. Employers Health Ins. Co.*, 722 F. Supp. 547, 552-53 (E.D. Wis. 1989). (claims for breach of contract, tortious interference with contract, and intentional infliction of emotional distress preempted by ERISA). The Court of Appeals found these omissions particularly disturbing in that Tomczyk's counsel had also been plaintiff's counsel in the *Rust* and *Meyer* cases.

Despite the existence of the controlling precedent cited above and the Court of Appeals' imposition of sanctions, Petitioner still persists in arguing that Wisconsin bad faith is a law regulating insurance and thus saved from ERISA preemption. Once again, Petitioner's counsel does not even acknowledge, much less attempt to distinguish or discuss the *Rust* and *Meyer* cases.

As support for the argument that Wisconsin bad faith law is saved from preemption, Petitioner once again cites *Anderson v. Continental Ins. Co.*, despite its clear holding that "*every* contract imposes upon each party a duty of good faith and fair dealing." 271 N.W.2d 368, 375, 85 Wis. 2d 675, 689 (1978) (emphasis added) Petitioner also cites Wisconsin Pattern Jury Instructions on bad faith as support for the erroneous contention that bad faith is exclusive to insurance cases.

Petitioner, however, fails to cite Wisconsin Pattern Jury Instruction 3044, "Good Faith." Res. App. 12. The Good

Faith instruction begins "Every contract implies good faith and fair dealing between the parties . . ." If a duty of good faith exists in every contract, that duty is capable of being breached. Breach of the duty of good faith surely means that a party has acted in bad faith, and damages may flow therefrom. Nowhere does Instruction 3044 state that it is limited to insurance cases. The instruction cites several authorities, including *In Re Estate of Chayka*, 47 Wis. 2d 102, 107, 176 N.W.2d 561, 564 (1970) (duty of good faith is implied condition in every contract, including a contract to make a joint will) and *Docter v. Furch*, 91 Wis. 464, 476-77, 65 N.W. 161, 164 (1895) (duty of good faith in contract to convey land).

Petitioner's argument that bad faith principles have been applied by Wisconsin courts in numerous insurance cases, but not specifically in employment cases fails to demonstrate that bad faith is a law solely regulating insurance and therefore saved from ERISA preemption. Petitioner provides no substantive refutation of the sound reasoning of *Pilot Life* followed by the *Rust* court, which was adhered to by the Court of Appeals in *Tomczyk*.

Other Extracontractual Damage Claims

While this Court in *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) expressly reserved judgment on whether extracontractual damages could be had under 29 U.S.C.§ 1132 (a) (3) (providing for "other equitable relief") the decision in *Russell* contains strong dicta to the effect that ERISA was not intended to provide extracontractual damages under *any* of its provisions.

> "Significantly, the statutory provision explicitly authorizing a beneficiary to bring an action to enforce his rights under

> the plan - §502 (a) (1) (B),...says nothing about the recovery of extracontractual damages, or about the possible consequences of delay in the plan administrator's processing of a disputed claim. Thus, there is really nothing at all in the statutory text to support the conclusion that such a delay gives rise to a private right of action for compensatory or punitive relief."

Id. at 144.

> "The six carefully integrated civil enforcement provisions found in §502 (a) of the statute as finally enacted, however, provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."

Id. at 146 (emphasis in original).

The Seventh Circuit Court of Appeals has likewise ruled that state law tort and contract claims may not be maintained against insurers of employee benefit plans. *See Maciosek v. Blue Cross & Blue Shield United of Wisconsin*, 930 F.2d 536 (7th Cir. 1991). In *Maciosek*, an action involving the denial of benefits under a health plan, the Seventh Circuit upheld the District Court's determination that the plaintiffs' claims for breach of contract, tortious interference with contract and intentional infliction of emotional distress under Wisconsin common law were preempted by ERISA. The Court rejected the plaintiffs' argument that these claims were "saved" from preemption because they were based on laws regulating insurance:

> "These claims do not qualify for the savings clause under any of the factors listed by the Supreme Court in *Pilot Life* . . . They do not specifically impact the insurance industry, but are laws of general application. Nor are they part of the "business

> of insurance" under the McCarran-Ferguson Act. Further, ERISA's civil enforcement scheme was designed to provide a remedy for these types of alleged wrongs . . . Finally, the claim is based on a circumstance—a dispute over employee insurance benefits—that the civil enforcement provisions of ERISA were designed to remedy. The district court properly held these claims preempted by ERISA."

Maciosek, 930 F.2d at 540 (citations omitted). See also *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416, 418 (7th Cir. 1988) *cert. denied* 488 U.S. 856 (1988)[2] and *Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987) (punitive damages unavailable).

The majority of other federal appellate courts which have considered this question have also rejected extra-contractual damages as a remedy under § 1132(a)(3). See *Bishop v. Osborn Transportation*, 838 F.2d 1173, 1174 (11th Cir. 1988) *cert. denied* 488 U.S. 832 (1988); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821, 824-825 (1st Cir. 1988) *cert. denied* 488 U.S. 909 (1988); *Varhola v. Doe*, 820 F.2d 809, 817 (6th Cir. 1987); *Sokol v. Bernstein*, 803 F.2d 532, 534-537 (9th Cir. 1986); *Sommers Drug Stores Co. v. Corrigan Enterprises*, 793 F.2d 1456, 1462-65 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 and 1089 (1987); *Powell v. Chesapeake and Potomoc Tel. Co.*, 780 F.2d 419, 424 (4th Cir. 1985), *cert. denied* 476 U.S. 1170 (1986); *Dependahl v. Falstaff Brewing Co.*, 653 F.2d 1208, 1216 (8th Cir. 1981) (dictum), *cert. denied* 454 U.S. 968 (1981).

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[2] Petitioner's Counsel was also counsel for the plaintiff in *Maciosek* and *Reilly*.

As the First Circuit said in *Drinkwater*, "'other appropriate equitable relief' should be interpreted to mean what it says—declaratory or injunctive relief, not compensatory and punitive damages." 846 F.2d at 824. "Equitable" relief implies relief that will make a person whole by restoring to him or her that to which he or she is entitled. It does not imply compensatory damages for inconvenience, worry, or emotional distress, or punitive damages designed to punish the plan administrator. *Eaton v. Blue Cross & Blue Shield of Ala.*, 681 F. Supp. 759, 762 (S.D. Ala. 1988). The legislative history of ERISA indicates that Congress intended to import to ERISA the fiduciary principles of trust law. *Id.*; *See also Kleinhans*, 810 F.2d at 627.

As the Ninth Circuit said in *Sokol*, "[p]erhaps the most telling indication of what congress meant by 'appropriate equitable relief' appears in the Senate Finance Committee report on ERISA:"

> "Appropriate equitable relief may be granted in a civil action. For example, injunctions may be granted to prevent a violation of fiduciary duty, and a constructive trust may be imposed on the plan assets, if needed to protect the participants and beneficiaries. Also, the bill specifically provides that a fiduciary may be removed through civil action brought by the Secretary or participants or beneficiaries if he has violated any of the specified fiduciary obligations. . . It is expected that a fiduciary. . . may be removed for repeated or substantial violations of his responsibilities, and that upon removal the court may, in its discretion, appoint someone to serve until a fiduciary is properly chosen in accordance with the plan."

803 F.2d at 538, (quoting S. Rep. No. 383, 93d Cong., 2d

Sess., *reprinted in* 1974 U.S. Code Cong. & Ad. News 4890, 4989). The above passage illustrates Congress' intent to afford such remedies as injunctive relief, constructive trust, and removal of the fiduciary. Thus, it appears that "Congress used the word 'equitable' to mean what it usually means—injunctive or declaratory relief." *Id.* (footnote omitted). The clear weight of authority holds that "equitable relief" under 29 U.S.C. §1132(a)(3) does not include extracontractual damages for plan beneficiaries.

Petitioner devotes the balance of the discussion on her extracontractual damage claims to arguing that state laws solely regulating insurance are saved from preemption and thus may be applied to insured ERISA plans. Respondent readily concedes this well established point. Respondent further readily concedes that the plan covering Tomczyk was an insured plan, subject to state insurance laws. However, in light of the fact that none of Tomczyk's common law claims are based on state laws solely regulating insurance, and therefore are not saved from preemption, her discussion of this point is wholly tangential.[3] The Court of Appeals

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[3] Apparently continuing the pattern observed by the Court of Appeals, Petitioner misstates the law. Petitioner asserts that *FMC Corp. v. Holliday*, 111 S. Ct. 403, 409 (1990) held that "the deemer clause *does not* exempt self-funded ERISA plans from state laws that regulate insurance within the meaning of the savings clause." Pet. at p. 14, emphasis added. In fact, *FMC* held precisely the opposite:

> "By forbidding States to deem employee benefit plans 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves plans from state laws 'purporting to regulate insurance.' As a result, self-funded

(Footnote continued on following page)

correctly affirmed the ruling of the District Court that Tomczyk's claims for extracontractual damages are preempted by ERISA.

C. The Imposition Of Sanctions On Petitioner's Counsel Does Not Constitute A Special Or Important Reason For Granting A Writ.

Tomczyk's counsel "implores" the Court to allow him the opportunity to "address the complexity of ERISA's . . . clauses and the ongoing dynamics of ERISA remedies." Pet. at p. 20. However, Tomczyk's counsel has been doing just that for years. The manner in which counsel has proceeded, however, does not justify further opportunity to tilt at windmills. The arguments advanced in proceedings below in this case are the same arguments that have been repeatedly advanced by this same counsel, often against this same defendant; arguments that have been consistently rejected by

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[3] Continued

> ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not 'saved' because they do not regulate insurance. *State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws."*

FMC at 409, emphasis added.

the District Courts and the Court of Appeals of this circuit. *See Rust* and *Meyers* supra at pp. 9-10 of this brief; *Smith v. Blue Cross & Blue Shield United of Wisconsin, et al.*, 724 F. Supp. 618 (E.D. Wis. 1989)[4]; *Maciosek v. Blue Cross & Blue Shield United of Wisconsin*, 930 F.2d 536 (7th Cir. 1991); *Robinson v. Blue Cross & Blue Shield United of Wisconsin, et al.*, No. 88-C-0435 (E.D. Wis. Apr. 5, 1991), Res. App. 13-14; *Koller v. Blue Cross & Blue Shield United of Wisconsin, et al.*, No. 87-C-903 (E.D. Wis. Jan. 29, 1991), Res. App. 15, 20-24, 28-30; *McGrew v. Blue Cross, et al.*, No. 87-C-1224 (E.D. Wis. Oct. 7, 1988), Res. App. 31-35.

The Petition presents no justification for allowing Tomczyk's counsel an opportunity to restate to this Court arguments which have been repeatedly and soundly rejected by the lower courts, and which fly in the face of controlling precedent, including numerous decisions of this Court.

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[4] The Seventh Circuit affirmed the District Court's ruling in *Smith* on March 27, 1992. See *Smith v. Blue Cross & Blue Shield United of Wisconsin, et al.*, 1992 U.S. App. LEXIS 5497. Res. App. 40-55.

CONCLUSION

Petitioner has failed to demonstrate special and important reasons for granting certiorari. For the reasons stated in this response and upon the rationale of the lower court decisions, respondent respectfully requests that the Petition for Writ of Certiorari be denied.

Respectfully submitted, April 1992.

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RESPONDENT'S

APPENDIX

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Case No. 87-C-0751

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
September 21, 1988, Decided and Filed

AMY RUST,

Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and WISCONSIN BELL, INCORPORATED,

Defendants.

OPINION BY: [*1]
WARREN
OPINION: DECISION AND ORDER
ROBERT W. WARREN,
UNITED STATES DISTRICT JUDGE

Plaintiff Amy Rust brought suit against defendants Blue Cross and Blue Shield United of Wisconsin, Wisconsin Bell, Inc., Mid-America Mutual Life Insurance Company and Francis Orval for damages allegedly arising out of her failure to receive insurance benefits following her divorce. Plaintiff alleged claims against Blue Cross for (1) bad faith, (2) economic duress, and (3) emotional distress; against Blue Cross and Wisconsin Bell, jointly, for (4) conspiracy; and against Mid-America for (5) breach of contract, (6) negligent misrepresentation, (7) bad faith, and (8) emotional distress.

Plaintiff sought compensatory and punitive damages.

Presently pending before the court is a joint motion by defendants Blue Cross and Wisconsin Bell for summary judgment. Defendants Blue Cross and Wisconsin Bell also have moved to strike plaintiff's jury demand.

I. BACKGROUND

A. Procedural History

Amy Rust brought suit in Milwaukee County Circuit Court on May 28, 1987. The case was removed to this court on June 19, 1987, by Wisconsin Bell pursuant to 28 U.S.C. § 1441. In a Stipulation and Order dated September 25, 1987, [*2] Mid-America and Francis Orval were dismissed from the case, leaving only the claims against Blue Cross and Wisconsin Bell.

The bad faith claim against Blue Cross alleged that Blue Cross refused to allow plaintiff to convert her health insurance group plan following her divorce. The Economic duress claim alleged that Blue Cross knew of plaintiff's difficult financial condition and attempted to use that knowledge to get plaintiff to abandon her rights. This conduct also allegedly caused plaintiff severe emotional distress, another claim. The conspiracy claim alleged that Blue Cross and Wisconsin Bell conspired to deprive plaintiff of her right to conversion of the medical plan.

At a status conference held November 16, 1987, the Court set a deadline for completing discovery and filing any dispositive motions. Pursuant to that schedule, Blue Cross and Wisconsin Bell timely filed the pending motions.

Defendants' motion for summary judgment contends that plaintiff's claims are based on state statutory and tort law, which are pre-empted under the Employee Retirement Income Security Act of 1974, (ERISA) 29 U.S.C. § 1001 et seq.

B. Undisputed Facts

The Court finds that from a review [*3] of the entire record now before the Court, the following facts are undisputed.

Amy Rust, a resident of Milwaukee, is the former spouse of Richard Rust, who was an employee of Wisconsin Bell in 1985. Wisconsin Bell and Blue Cross are both Wisconsin corporations. While the Rusts were married, and while Mr. Rust worked at Wisconsin Bell, Amy Rust was covered as a dependent spouse under a group "Medical Expense Plan" sponsored by Wisconsin Bell and administered by Blue Cross. Plaintiff does not dispute that this plan qualifies as an "employee welfare benefit plan" within the meaning of ERISA.

In November of 1984, Amy Rust became divorced from her husband. Based upon statements made by her husband, Amy Rust believed that her insurance coverage through Wisconsin Bell would end immediately upon her divorce. She did not verify this information with either Wisconsin Bell or Blue Cross.

Amy Rust subsequently obtained health insurance coverage with Mid-America Mutual Insurance Company. In December of 1985, she fell and sustained injuries that required hospitalization. She filed claims with Mid-America,

but Mid-America rejected her claims. She did not submit any claims to Blue Cross for treatment [*4] she received as a result of her injuries.

C. Disputed Facts

Amy Rust, in her complaint and in an affidavit, states that sometime during 1986, she sent a letter to Blue Cross and Wisconsin Bell which read as follows.

To whom it may concern

I am the former wife of Richard Rust, an employee of Wisconsin Bell. Since our divorce, my coverage under Blue Cross/Blue Shield ceased as of 12-1-85. I never did get any type of notice that I could retain said insurance or to convert said insurance so that I would still be provided with coverage after 12-1-85. I have since incurred medical bills because of a fall on ice on Dec. 2, 1985, and I have no insurance coverage.

Please advise immediately as to what I should do in order to retain Blue Cross coverage that was in effect.

Thank You–

Amy Rust
6817 N. 45th St.
Milw. Wisc. 53223

She further states in her affidavit that on May 8, 1986, she received a telephone call from a representative of Blue Cross and was informed by that representative that it was not

Blue Cross' policy to notify ex-spouses of their conversion privileges. She also was informed that she could not covert her insurance coverage and, instead, was advised that she take [*5] out private health insurance.

Blue Cross denies that it ever took any action to terminate plaintiff's coverage and instead states that according to its records, Amy Rust is still an eligible participant of the Wisconsin Bell Plan. Blue Cross also denies that it ever received a copy of the letter plaintiff claimed to send. Blue Cross further states that it keeps records of all telephone contacts with policyholders, but that it has no record of any contact with plaintiff regarding conversion coverage.

II. ANALYSIS

Defendants' motion for summary judgment argues that plaintiff's case is an ERISA-based action arising from an employee welfare benefit plan. As an ERISA-based action, plaintiff must proceed under 29 U.S.C. § 1132 (a) (1) (B), which provides that a participant or beneficiary of an employee welfare benefit plan may bring a civil action to recover benefits due under the plan, to enforce rights under the terms of the plan, or to clarify his rights to future benefits under the plan. Furthermore, plaintiff's claims arising under state law–bad faith, economic duress, emotional distress, conspiracy and punitive damages–are preempted under 29 U.S.C. § 1144, which holds that ERISA [*6] supersedes all state laws insofar as they relate to any employee benefit plan.

Plaintiff responds that "the only issue of relevancy" in this case "centers around defendant's unreasonable refusal to convert plaintiff's health insurance as required by Sec. 632.897, Wis. Stat." Plaintiff's Brief in Opposition to

Defendant's Motion for Summary Judgment at 3. Section 632.897 (2) (b) provides that an insurer of a group plan must allow three months for a group member's former spouse, who would otherwise have her coverage terminated because of the divorce, to elect to continue group policy coverage or convert to individual coverage. Plaintiff further contends that her claims arising from this and other Wisconsin law are "saved" from pre-emption under 29 U.S.C. § 1144 (b) (2) (A), which provides that ERISA does not preempt state laws which regulate insurance.

The court begins by finding that a resolution of defendants' summary judgment motion does not involve a resolution of the disputed facts listed above. n1 Since plaintiff does not dispute that the Wisconsin Bell group medical expense plan qualifies as an employee welfare plan under ERISA, the sole issue before the Court is whether plaintiff's [*7] state action is pre-empted by federal law. This interpretation of federal and state law is a question of law based on the intent of Congress. *See Pilot Life Insurance Company v. Dedeaux*, 107 S. Ct. 1549 (1987). The Supreme Court's decision in *Pilot Life v. Dedeaux* addressed the same issue now before this Court in determining whether ERISA pre-empted the Mississippi law of bad faith. The court began its analysis by reviewing and summarizing the applicable ERISA provisions.

Congress capped off the massive undertaking of ERISA with three provisions relating to the pre-emptive effect of the federal legislation:

"Except as otherwise provided in subsection (b) of this section [the saving clause], the provisions of this subchapter

and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan..." section 514(a), as set forth in 29 U.S.C. § 1141(a) (pre-emption clause).

"Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." section 514 (b) (2) (A), [*8] as set forth in 29 U.S.C. § 1144 (b) (2) (A) (saving clause).

"Neither an employee benefit plan...nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." Section 514 (b) (2) (B), 29 U.S.C. § 1144 (b) (2) (B) (deemer clause).

To summarize the pure mechanics of the provisions quoted above: If a state law "relate[s] to...employee benefit plan[s]," it is pre-empted. Section 514 (a). The saving clause excepts from the pre-emption clause laws that "regulate[e] insurance." Section 514 (b) (2) (A). The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. Section 514 (b) (2) (B)...

In Metropolitan Life [Insurance v. Massachusetts, 471 U.S. 724 (1985)], we were guided by several considerations in determining whether a state law falls under the saving

clause. First, we took what guidance was available [*9] from a "common-sense" view of the language of the saving clause itself. 471 U.S., at 740...Second, we made use of the case law interpreting the phrase "business of insurance" under the McCarran-Ferguson act, 15 U.S.C. § 1011 et seq., in interpreting the clause. Three criteria have been used to determine whether a practice falls under the "business of insurance" for purposes of the McCarran-Ferguson Act:

[F]irst, whether the practice has the effect of transferring or spreading policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. *Union Labor Life Ins. Co. v. Pireno*, 485 U.S. 119, 129 (1982)...

107 S. Ct. at 1551-1554.

n1 Rule 56 of the Federal Rules of Civil Procedure provides that summary judgment shall be granted if the record shows that "there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Black v. Henry Pratt Company*, 778 F. 2d 1278, 1281 (7th Cir. 1985). The party moving for summary judgment has the burden of establishing that there is no genuine issue of material fact. *Egger v. Phillips*, 710 F. 2d 292, 296 (7th Cir.), cert. denied, 464 U.S. 918 (1983). The Court must review the entire record with all reasonable inferences drawn from it taken in a light most favorable to the nonmoving party. *Reardon v. Wroan*, 811 F. 2d 1025, 1027 (7th Cir. 1987). [*10]

Turning to the case at hand, the Court finds that plaintiff's claims arising out of or dependent on a violation of section

632.897 (2) (b), Wis. Stats., are pre-empted by ERISA. First, there can be no dispute that the Wisconsin statute relates to an employee benefit plan as defined by ERISA. Compare 29 U.S.C. § 1002(1) with Wis. Stat. § 632.897 (1) (c) 2, 3. Second, the subsection of section 632.897 at issue in this case, (2) (b), governs the continuation of a "group policy" in the case of a divorce. By definition, however, that regulation of "group policy" cannot be deemed a regulation of an employee welfare benefit plan. 29 U.S.C. § 1144 (b) (2) (B). Thus, even though the statute governs insurers as well as plans, the regulation of the plans cannot escape pre-emption. *See General Split Corporation v. Mitchell*, 523 F. Supp. 427, 430-31 (E.D. Wis. 1981) (Gordon, J.) (finding Wis. Stat. 639.897 pre-empted by ERISA on that basis).

Plaintiff alleged claims for bad faith, economic duress, emotional distress and conspiracy, though she does not make clear in her summary judgment response which of these actions are not dependent on a violation of Wis. Stat. § 632.897 (2) (b). Both sides, [*11] however, did discuss whether the tort of bad faith was pre-empted independent of section 632.897 (a) (b).

In *Anderson v. Continental Insurance Company*, 85 Wis. 2d 675, 689, 271 N.W. 2d 368, 375 (1978), the Wisconsin Supreme Court stated that "*every* contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." (Emphasis added.) Thus, since the Wisconsin tort applies to "every contract," not just insurance contracts, bad faith would not meet the requirements of the savings clause under either a common-sense understanding of the phrase "regulates insurance," *see* 107 S. Ct. at 1554, or under an examination of whether the tort is limited to the

insurance industry. Furthermore, the tort of bad faith cannot be said to have an impact on the spreading of policyholder risk, nor is the tort an integral part of the relationship between insured and an insurer. *See Pilot Life*, at 1554-1555 (bad faith tort applies no differently to insurance contract than any other contract). In sum, the analysis of the Wisconsin bad faith tort is almost identical to that of the Supreme Court on Mississippi's bad faith tort. The conclusions certainly [*12] are: the Court finds the Wisconsin tort of bad faith is pre-empted by ERISA.

Again, the parties do not present any explicit analysis on the remaining claims. In light of the Supreme Court's holding in *Pilot Life*, as well as this Court's similar conclusions above, it is difficult for the Court to imagine that the appropriate analysis would be any different from that used for bad faith. Plaintiff offers no Wisconsin law in support of the proposition that the torts apply solely to the insurance industry, that they would spread policyholder risk or that they are an integral part of the relationship between the insured and the insurer. Therefore, to the extent these torts are not pre-empted by their reliance on a violation of the duty imposed by section 632.897, Wis. Stats., the Court finds they are pre-empted under ERISA by the supreme Court's analysis in Pilot Life.

Defendants have also moved to strike plaintiff's jury demand on the basis that ERISA does not provide a right to a jury trial. The Court, however, is unclear on the purpose of this motion. The analysis above eliminates all of plaintiff's pending claims. Plaintiff has not indicated an intention to proceed on ERISA [*13] grounds nor did she request leave to amend the complaint if the Court were to find the state law claims preempted. Defendant's summary judgment motion,

however, seemed to leave the door open for plaintiff to proceed under ERISA. See Brief in Support of Summary Judgment Motion at 6. ("While plaintiff's Complaint makes no specific reference to ERISA, it is clear that the claim is, in actuality, a claim for benefits from the employee benefit plan maintained by Wisconsin Bell.") Therefore, the Court will hold in abeyance the motion to strike the jury demand, pending a discussion on these points with the parties at a status conference.

III. SUMMARY

Plaintiff's suit against Wisconsin Bell and Blue Cross arises out of an employee welfare plan maintained by Wisconsin Bell and administered by Blue Cross. The suit alleges claims under state law for bad faith, economic duress, emotional distress, and conspiracy and relies on duties imposed on group medical plans by Wis. Stat. § 632.897. The state law-based claims, however, are pre-empted by the pre-emption clause of ERISA, 29 U.S.C. §1441(a). The claims are not excepted from pre-emption by ERISA's saving clause, 29 U.S.C. § 1144 (b) (2) (A). [*14] Accordingly, the Court hereby GRANTS the motion of Blue Cross and Wisconsin Bell for summary judgment on plaintiff's bad faith, economic duress, emotional distress, and conspiracy claims.

Defendant's motion to strike plaintiff's jury demand is hereby HELD IN ABEYANCE.

To discuss further proceedings in this case, the Court will hold a status conference at 9:30 a.m. on Thursday, October 6, 1988, in Room 390, Federal Building, 517 East Wisconsin Avenue, Milwaukee, Wisconsin.

SO ORDERED this 21st day of September, 1988, at Milwaukee, Wisconsin.

3044 GOOD FAITH

Every contract implies good faith and fair dealing between the parties and a duty of cooperation on the part of both parties. The law implies a promise against arbitrary or unreasonable conduct.

Good faith means honesty in fact in the conduct or transaction concerned, that is, an honest intention to abstain from taking unfair advantage of another, through technicalities of law, by failure to provide information or to give notice, or by other activities which render the transaction unfair.

There must be an adherence to those reasonable standards of fair dealing which the parties, taking into account the circumstances in which they are doing business, have a right to expect.

Good faith is required at every point, from negotiation through performance.

COMMENT

Estate of Chayka, 47 Wis 2d 102, 176 NW 2d 561 (1970); Wis Stat § 401.203.

17 Am Jur 2d *Contracts* § 256.

Wis Stat § 401.201 (19).

Black's ~~Law~~ Dictionary; *Docter v Furch*, 91 Wis 464, 65 NW 161 (1895); 54 Marq L Rev 1 (1971).

Res. App. 13

Case No. 88-C-0435

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
April 5, 1991

CAROLYN ROBINSON and DERRICK ROBINSON,

Plaintiffs,

v.

COMPCARE HEALTH SERVICES INSURANCE CORPORATION, BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and BRIGGS AND STRATTON CORP,

Defendants.

ORDER OF PARTIAL DISMISSAL

The motion of the defendants Compcare Health Services and Blue Cross & Blue Shield United of Wisconsin to dismiss the complaint herein having been heard and considered by the court, IT IS HEREBY ORDERED AS FOLLOWS:

1. The plaintiffs' claims for "contract damages," "misrepresentation," "bad faith," "tortious interference with contract," "gross conduct outside the scope of ERISA," and "intentional infliction of emotional distress" are DISMISSED on the ground that they do not state a claim upon which relief may be granted under the federal law governing this action,

that being the Employee Retirement Income Security act of 1974, (ERISA) 29 U.S.C. §1001 et seq.

2. The plaintiffs' claim for "breach of fiduciary duty" is DISMISSED as it is alleged in a purely private capacity and any cause of action under ERISA for breach of fiduciary duty inures solely to the benefit of the plan. Therefore, the plaintiff's claim for breach of fiduciary duty, as alleged, does not state a claim on which relief may be granted.

3. The plaintiffs' claim for violation of civil rights under color of state law is DISMISSED on the ground that no state action is alleged, state action being a necessary element of a §1983 claim. Therefore, this alleged cause of action fails to state a claim upon which relief may be granted.

4. The plaintiffs' complaint shall survive dismissal in its entirety on the ground that the complaint appears to arise out of a denial of benefits allegedly due under the terms of an ERISA plan, thus stating a claim under 29 U.S.C. §1132 (a) (1) (B).

BY THE COURT:
/s/ J.P. Stadtmueller
J.P. STADTMUELLER
District Court Judge

LB9L.DMW

Res. App. 15

Civil Action No. 87-C-903 (JPS)

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
January 29, 1991

ANN KOLLER and HENRY KOLLER, JR.,

Plaintiffs,,

v.

AETNA LIFE INSURANCE CO.,
BLUE CROSS AND BLUE SHIELD
UNITED OF WISCONSIN
and BRIGGS & STRATTON CORP.,

Defendants

DECISION AND ORDER

APPEARANCES:

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Ann and Henry Koller commenced this action in Milwaukee County Circuit Court after the defendants, Aetna Life Insurance Company ("Aetna"), Briggs & Stratton Corporation ("Briggs & Stratton"), and Blue Cross & Blue Shield United of Wisconsin ("Blue Cross"), refused to cover portions of Ms. Koller's cancer treatment. The case was removed to this court because it raises questions governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. In their multi-count complaint, the Kollers set forth claims for breach of contract, misrepresentation, bad faith denial of insurance benefits, tortious interference with contract, gross conduct outside of the scope or ERISA, breach of fiduciary duty, and intentional infliction of emotional distress. They seek compensatory and punitive damages.

Presently before the court are Aetna and Briggs & Stratton's joint motions for summary judgment and to strike the Kollers' demand for a jury trial, and Blue Cross' motion for summary judgment.

I. Background

The pertinent facts are taken from the complaint and from affidavits submitted by the parties.

A. The Plans

Ann Koller is a Briggs & Stratton employee and a participant in the Briggs & Stratton Benefit Plan for Hourly Employees ("B&S Plan"). The B&S Plan is a self-insured benefit plan funded entirely by Briggs & Stratton. Claims for benefits are processed by Aetna, which decides whether the submitted charges are covered. The plan covers only services or supplies that are "medically necessary," which means that the service or supply must be broadly accepted professionally as essential to the treatment of the disease or injury. Aetna is not at risk for any health care costs.

Ms. Koller is also covered as a dependent under a health plan sponsored by her husband's employer, Western Industries, Inc. The Western Industries' plan ("WI Plan"), like the B&S Plan, is self-insured. Blue Cross processes and pays claims for benefits, then is reimbursed by Western Industries. The WI Plan has a coordination of benefits (COB) provision, which affects benefit payments. Under this provision, a plan that covers an individual "other than as a dependent" is deemed to pay its benefits before a plan that covers the individual as a "dependent." In this case, the mechanics of the COB provision operate to reduce the benefits payable to Ms. Koller under the WI Plan by the amount payable under the B&S Plan. The WI Plan also authorizes Blue Cross to obtain, without the consent of any party, any information needed to implement the COB provision.

B. The Claims and Denials

In 1986, Ms. Koller discovered a lump in her left breast. A biopsy revealed that the lump was cancerous. A modified mastectomy was performed on July 14, 1986. Following the

surgery, Ms. Koller's physician, Dr. Burton Waisbren, Sr., prescribed several months of immunotherapy and chemotherapy.

Aetna covered Ms. Koller's surgery, but referred her claims for the immunotherapy and chemotherapy to its medical consultant, Dr. Henry M. Williams, a board certified oncologist. Based on Dr. Williams' advice, Aetna concluded that the immunotherapy and chemotherapy were not medically necessary and therefore not covered under the B&S Plan. Aetna notified Ms. Koller of its decision in a letter dated March 2, 1987. Aetna also pointed out that its decision was preliminary and that a final decision would not be made until after it received certain medical records from Dr. Waisbren. Aetna further agreed to review any other information that Dr. Waisbren considered pertinent.

After obtaining the additional records, Aetna re-evaluated Ms. Koller's claims. In a letter dated April 16, 1987, Aetna informed her that its initial determination was unchanged and that coverage would not be provided.

Dr. Williams later summarized the bases for his opinion in a June 3, 1987 letter to Dr. William C. Curtis, the medical director at Briggs & Stratton. Dr. Williams stated that immunotherapy had not been shown to be an effective treatment for breast cancer and therefore was not considered usual and customary or medically necessary. He also stated that patients with Stage I breast cancer, like Ms. Koller, were not considered candidates for chemotherapy by practicing oncologists. This led him to conclude that the therapy was investigational rather than medically necessary. To assure that his, as well as Aetna's, conclusions were fair and consistent

with accepted clinical practice, Dr. Williams recommended that a board certified oncologist perform an independent medical examination on Ms. Koller.

Consistent with that recommendation, Ms. Koller was examined by Dr. Edward V. Filmanowicz, a prominent Milwaukee area oncologist, on July 2, 1987. Dr. Filmanowicz consulted with Dr. Ernest Borden of the University of Wisconsin at Madison and Dr. Thomas Anderson of the Medical College of Wisconsin, both professors of oncology at their respective institutions. Dr. Filmanowicz reported their findings in a July 27, 1987 letter to Aetna. All three physicians agreed that immunotherapy for breast cancer patients remains a matter of research and does not constitute a standard of care. They further agreed that while "adjuvant chemotherapy" (the type of chemotherapy given to Ms. Koller) is generally not done in stage I breast patients, it would be difficult to be extremely critical in this case.

Finding herself unable to collect from Aetna, Ms. Koller submitted her immunotherapy and chemotherapy bills to Blue Cross. Blue Cross denied the claims, in accordance with he coordination of benefit (COB) provisions of the WI Plan, for failure to first submit them the the primary carrier.

II. Discussion

The defendants contended that the B&S and WI Plans are employee benefit plans within the meaning of 29 U.S.C. 1002(3) and therefore governed by ERISA. As such, they argue that the Kollers' state law claims are preempted under 29 U.S.C. § 1144. They also contend that in reviewing the denial of ERISA benefits, the court is bound by the decision of the plan administrator unless that decision was arbitrary or

capricious.

The Kollers do not dispute the applicability of ERISA. Instead, they insist that ERISA does not preempt state laws regulating insurance. They further argue that the arbitrary and capricious standard of review is inappropriate and that the court should conduct a *de novo* review.

A. Summary Judgment Standard

Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Howland v. Kilquist*, 833 F. 2d 639, 642 (7th Cir. 1987); Fed. R. Civ. P. 56(c). In considering such a motion, the court must view the facts in the light most favorable to the nonmoving party, giving that party the benefit of every reasonable inference that can be drawn from those facts. *Smart v. State Farm Insurance Co.*, 868 F. 2d 929, 931 (7th Cir. 1989). Although the moving party has the burden of showing there are no material facts in dispute, this does not mean that the nonmoving party can simply rest on the pleadings. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 256 (1986). Quite the contrary, to defeat a properly supported motion the nonmoving party must produce sufficient evidence for a jury to return a verdict in his favor. *Anderson*, 477 U.S. at 249.

B. Does ERISA Preempt the Kollers' State Law Claims?

Since the Kollers do not dispute that the B&S and WI plans qualify as employee welfare benefit plans, the first issue the court must address is whether the couple's state law claims–breach of contract, misrepresentation, bad faith, tortious interference with contract, breach of fiduciary duty,

and intentional infliction of emotional distress–and their demand for punitive damages are preempted by ERISA.

The language, structure, and legislative history of ERISA proves convincingly that Congress intended the regulation of employee benefit plans to be an exclusively federal concern.

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...

29 U.S.C. § 1144 (a). The Kollers correctly point out that state laws regulating insurance are not preempted because of ERISA's "savings clause," 29 U.S.C. § 1144 (b) (2) (A). Their analysis, however, ignores the so-called "deemer clause:"

> Neither an employee benefit plan...nor any trust established under such a plan shall be deemed to be an insurance company or other insurer...or to be engaged in the business of insurance...for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts...

29 U.S.C. § 1144 (b) (2) (B). The "deemer clause" prevents an employee benefit plan from being regarded as an insurance company, insurer, or in the business of insurance simply because the plan is self-insured. Consequently, though insured plans (those that purchase insurance) are subject to state laws that "regulate insurance," self-insured plans are not. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). *See also Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F. 2d 416, 425 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988).

The Kollers appear to concede that the WI plan is self-insured. *See* Plaintiffs' Brief in Opposition to Defendant Blue Cross and Blue Shield United of Wisconsin's Motion for Summary Judgment at 14, 15 [hereinafter Plaintiffs' Brief Opposing Blue Cross]. With respect to their claims against Aetna and Briggs & Stratton, they lamely attempt to avoid the holding in *Metropolitan Life* by asserting "[i]t is unclear whether or not Aetna is partially, entirely, or not funded at all by Briggs & Stratton." Plaintiffs' Brief on Opposition to Defendants Aetna Life Insurance Company and Briggs & Stratton Corporation's Motions for Summary Judgment and to Strike Jury Demand at 10 [hereinafter Plaintiffs' Brief Opposing Aetna]. The record, however, clearly indicates that the B&S plan is self-insured; funded entirely by Briggs & Stratton. Wurzer affidavit, ¶ 3.

Moreover, the insured/self-insured distinction would be relevant only if the Kollers' claims were based on state laws that regulate insurance. To regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry. *Pilot Life ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Claims for breach of contract, misrepresentation, tortious interference with contract, breach of fiduciary duty, and intentional infliction of emotional distress stem from general principles of tort and contract law applicable to all industries, not just the insurance industry. Similarly, one branch of this court has found that the Wisconsin tort of bad faith applies no differently to insurance contracts than to any other contract. *Rust v. Blue Cross & Blue Shield United of Wisconsin*, 1988 U.S. Dist. LEXIS 17207 (E.D. Wis. 1988).

In sum, the court finds that the Kollers' state law claims

and demand for punitive damages are preempted by ERISA. Accordingly, the defendants' motions for summary judgment on these claims will be granted and the claims will be dismissed.

C. ERISA Claims

The fifth claim in the Kollers' complaint alleges "gross conduct outside the scope of ERISA." Complaint ¶ 28. The court is uncertain just what this means, but since the couple has indicated a desire to proceed on ERISA grounds in the event their state law claims are preempted, Plaintiffs' Brief Opposing Aetna at 10; Plaintiffs' Brief Opposing Blue Cross at 9, the court will construe the claim as one for relief under 29 U.S.C. § 1132(a).

ERISA permits a participant or beneficiary of an employee benefit plan to bring a civil action to recover benefits allegedly due under the plan. 29 U.S.C. § 1132 (a) (1) (B). The statute, however, does not specify the standard of review to be used in evaluating claims for wrongful denial of benefits. After this suit was filed the Supreme Court handed down its decision in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), which altered the standard of review of a plan administrator's decision to deny ERISA benefits.

Before *Bruch*, courts generally deferred to the judgment of plan administrators, reversing their decisions only if they were "arbitrary and capricious." *See, e.g., Pokratz v. Jones Dairy Farm*, 771 F. 2d 206, 208 (7th Cir. 1985) and cases cited therein. In *Bruch*, the Court, guided by principles of trust law, held that "a denial of benefits challenged under 1132 (a) (1) (B) is to be reviewed under a *de novo* standard

unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115. The purpose of *de novo* review is to provide greater assurance that employees will get the plan benefits to which they are entitled. Under the *de novo* standard, the court independently construes the term of the plan to determine whether the administrator's decision was proper.

Shortly after *Bruch* was decided, the defendants submitted supplemental correspondence explaining why their decisions should be reviewed under the arbitrary and capricious standard. Aetna and Briggs & Stratton, evidently conceding that the B&S Plan does not grant discretionary authority to them, contend that *Bruch* should not be applied retroactively. Blue Cross, on the other hand, argues that there is a grant to discretion in the WI Plan. These arguments will be addressed separately.

1. Retroactive Application of *Bruch*

For a decision to be applied only prospectively, it must satisfy the three-prong test put forth in *Chevron Oil Co. v. Huson*, 404 U.S. 97 (1971). The decision must (1) establish a new principle of law, either by overruling clear past precedent or by deciding an issue of first impression; (2) state a rule that would be retarded rather than furthered by retroactive application, given the rule's history, purpose, and effect; and (3) if applied retroactively, produce substantial inequitable results–results that would be avoided by prospective application only.

Id. at 106-07.

Applying this test, the court concludes *Bruch* should be applied retroactively. While *Bruch*, by substantially changing the standard of review in benefit cases, easily satisfies the first prong of the Chevron test, it does not satisfy the second and third prongs. Before enactment of ERISA, actions challenging an employer's denial of benefits were governed by principles of contract law. *Bruch*, 489 U.S. at 112. The court reviewed an employee's claim as it would any other contract claim–by looking at the terms of the plan and other manifestations of the parties' intent. *Id.* at 112-13. ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans and to protect contractually defined benefits. *Id.* at 113. Yet under the arbitrary and capricious standard, employees and beneficiaries actually enjoyed less protection than they did before ERISA was enacted. *De novo* review remedies this problem as such, applying it retroactively would further rather than retard the goals of ERISA.

Furthermore, retroactive application of *Bruch* in this case would not produce substantial inequities. Although Aetna and Briggs & Stratton may have relied on the arbitrary and capricious standard in structuring the B&S Plan, *de novo* review does not increase their liability under the plan, it simply increases the probability that the court will disagree with their interpretation of the plan. The court rejects the notion that Aetna, Briggs & Stratton, and Blue Cross will suffer substantial hardship simply because they were counting on greater deference for an interpretation that may not be supported by the terms of the plan.

2. Application of the Bruch Standard to Aetna and Briggs & Stratton

Both sides have submitted affidavits on the issue of whether immunotherapy and chemotherapy were medically necessary for the treatment of Ms. Koller. Aetna and Briggs & Stratton rely on the previously discussed findings of Drs. Williams and Filmanowicz to support their position. Wurzer affidavit, Exhibits D, G. The Kollers counter with an affidavit from Dr. Waisbren who asserts that the treatments were not only medically necessary, but also were accepted by a large segment of the medical community. Waisbren affidavit, ¶¶ 2, 3. Ironically, this assertion is buttressed somewhat by Dr. Filmanowicz's concession that it is difficult to be extremely critical of the use of adjuvant chemotherapy in this instance. Wurzer affidavit, Exhibit G.

At this juncture, the court cannot say whether Aetna and Briggs & Stratton's decision to deny benefits was proper. Obviously, a material factual dispute remains as to the medical necessity of immunotherapy and chemotherapy. Accordingly, Aetna and Briggs & Stratton's joint motion for summary judgment on the ERISA claim will be denied.

3. Discretionary Authority of Blue Cross

Blue Cross purportedly derives its discretionary authority from two sources: (1) Section C of the Coordination of Benefits provision, which authorizes Blue Cross to release or obtain any information necessary to properly administer the COB provision without the consent of any party; and, (2) the General Exclusions (GE) provision, which authorizes Blue Cross to determine whether a treatment, service or supply is generally accepted medical practice and eligible for payment.

The Seventh Circuit has stated that no "magic words" (such as "the committee has discretion to...") are required to

vest the administrator with sufficient discretion to avoid *de novo* review. *Bali v. Blue Cross & Blue Shield Ass'n.*, 873 F. 2d 1043, 1047, (7th Cir. 1989). Furthermore, at least one court has read *Bruch* to exempt from *de novo* review not just decisions of administrators whose plans granted them discretionary authority, but also denials of benefits not based on plan interpretations. *Petrilli v. Drechsel*, 1989, U.S. Dist. LEXIS 10763 (N.D. Ill. 1989), *rev'd on other grounds*, 910 F. 2d 1441, 1447 (7th Cir. 1990). Resolution of the appropriate standard of review in this instance, however, must wait until another day since a material fact is in dispute.

As noted earlier, under the WI Plan's COB provision the B&S Plan is deemed to pay its benefits first since the WI Plan covers Ms. Koller only as a dependent. According to Blue Cross, the only way it could verify that Ms. Koller had submitted her claims to Aetna (her primary carrier) before sending them to Blue Cross was by obtaining documentation indicating Aetna had processed the claim. The most common form of documentation is an explanation of benefits (EOB). Kathleen Jury, Dr. Waisbren's office manager, insists that she not only billed Aetna first but also sent a copy of Aetna's EOB to Blue Cross when it was billed. Jury affidavit, ¶ 4. Blue Cross admits receiving some EOB's from Dr. Waisbren's office, but not for the claims in question. It goes on to call the inference from Ms. Jury's statement–that it denied 25 claims, over six months, from the same subscriber, for the same wrong reason–preposterous.

Suffice to say, the outcome of this question will have to be determined at trial. Accordingly Blue Cross' motion for summary judgment on the ERISA claim will be denied.

D. Punitive Damages under ERISA

In their complaint, the Kollers seek punitive damages and in their briefs they argue that they are entitled to such damages under 29 U.S.C. § 1132 (a) (3), despite the overwhelming precedent to the contrary. *See, e.g., Amos v. Blue Cross-Blue Shield*, 868 F. 2d 430, 431 (11th Cir.), cert. denied, 493 U.S. _____, 110 S. Ct. 158 (1989); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F. 2d 821, 825 (1st Cir.), *cert. denied*, 488 U.S. 909 (1988); *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F. 2d 1302, 1307 (9th Cir. 1986); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F. 2d 1456, 1463 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987); Powell v. Chesapeake and Potomac Tel. Co., 780 F. 2d 419, 424 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986). Their analysis of the pertinent case law conveniently overlooks *Kleinhans v. Lisle Sav. Profit Sharing Trust*, 810 F. 2d 618 (7th Cir. 1987) in which the Seventh Circuit explicitly stated that punitive damages are not recoverable under § 1132 (a) (3) of ERISA. *Id.* at 627. Furthermore, as the Supreme Court pointed out in *Bruch*, ERISA should be interpreted consistent with the principles of trust law. 489 U.S. at 110-15. In the trust context, punitive damages are generally awarded only when malice or fraud is involved, G. BOGERT & G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 862 (rev. 2d ed. 1982), neither of which was pleaded here.

E. Right to a Jury Trial

Finally, the defendants have moved to strike the Kollers' demand for a jury trial. Citing *Wardle v. Central States, Southeast & Southwest Areas Pension Fund*, 627 F. 2d 820

(7th Cir. 1980), *cert. denied*, 449 U.S. 1112 (1981), the defendants argue that since ERISA claims are of an equitable nature, no right to a jury trial exists. The Second, Third, Fourth, Sixth, Eight and Eleventh Circuits have reached the same conclusion. *See, e.g. Blake v. Unionmutual Stock Life Ins. Co.*, 906 F. 2d 1525, 1526 (11th Cir. 1990); *Cox v. Keystone Carbon Co.* 894 F. 2d 647 (3rd Cir.), *cert. denied*, 498 U.S. _____, 111 S. Ct. 47 (1990); *Daniel v. Eaton Corp.*, 839 F. 2d 263, 268 (6th Cir.), *cert. denied*, 488 U.S. 826 (1988); *Berry v. Ciba-Geigy Corp.*, 761 F. 2d 1003, 1006-07 (4th Cir. 1985); *Katsaros v. Cody*, 744 F. 2d 270 (2d Cir.), *cert. denied*, 469 U.S. 1072 (1984); *In re Vorpahl*, 695 F. 2d 318 (8th Cir. 1982).

In light of the prevailing case law, the court is compelled to conclude that the Kollers do not have a right to a jury trial under ERISA. Nor does the court believe that the heightened review mandated by *Bruch* dictate a different conclusion because the nature of the action is unaffected by the standard of review. *See Blake*, 906 F. 2d at 1526. Although the Kollers are claiming money damages, in effect they are seeking to enforce their benefits under the two plans. Assuming Ms. Koller required additional treatment, the appropriate remedy would be an order to provide benefits–an equitable remedy.

III. Conclusion

To summarize, the Kollers' state law claims for beach of contract, misrepresentation, bad faith, tortious interference with contract, breach of fiduciary duty, and intentional infliction of emotional distress, as well as any state law demand for punitive damages are preempted by ERISA and must be dismissed. Summary judgment of the ERISA claims

is inappropriate because there are material facts still in dispute. The Kollers, however, are not entitled to punitive damages or to a jury trial on their ERISA claim.

Therefore,

IT IS ORDERED that the defendants' motions for summary judgment on the claims of beach of contract, misrepresentation, bad faith, tortious interference with contract, breach of fiduciary duty, and intentional infliction of emotional distress be and the same are hereby **GRANTED**; and,

IT IS FURTHER ORDERED that the defendants' motions for summary judgment on the ERISA claims be and the same are hereby **DENIED**; and,

IT IS FURTHER ORDERED that the plaintiffs' demand for punitive damages be and the same is hereby **DENIED**; and

IT IS FURTHER ORDERED that the defendants' motion to strike the plaintiffs' demand for a jury trial on the ERISA claims be and the same is hereby **GRANTED**.

Dated at Milwaukee, Wisconsin this 29th Day of January, 1991.

BY THE COURT;
/s/J.P. Statmueller
J.P. Statmueller
U.S. District Judge

Res. App. 31

Civil Action No. 87-C-1224

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
October 7, 1988

EMMA McGREW and BENNIE McGREW,

Plaintiffs,

v.

WISCONSIN PHYSICIANS SERVICE INSURANCE CORP., BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and MILWAUKEE COUNTY,

Defendants.

ORDER

Currently pending are motions of the defendants for dismissal of the action or for summary judgment.

The undisputed facts show that Emma McGrew is an employee of Milwaukee County. Since January 1, 1985, the county has furnished a health benefits plan to its employees, retirees, and their dependents. The plan is self-funded and is administered by Wisconsin Physicians Service. As a county employee, Mrs. McGrew has WPS as her primary insurance carrier.

Bennie McGrew is a retiree of the Ladish Company. He also had family health coverage under which Mrs. McGrew

was covered as a dependent spouse. His plan is a self-insured plan sponsored by the Ladish Company and administered by Blue Cross & Blue Shield United of Wisconsin.

The Ladish plan contains a "Coordination of Benefits" clause, which requires that claims first be presented to the insured's primary carrier. If that carrier rejects a claim, it can then be presented to Blue Cross.

Emma McGrew has a condition diagnosed as chronic lymphatic leukemia and osteomyelitis. She has been a patient of Dr. Burton Waisbren, Sr. of the Waisbren Clinic since April 1985. During that time she has received immunotherapy treatments on a monthly basis.

Some of her bills submitted to WPS for the immunotherapy treatments were paid initially. However, WPS has subsequently refused payment of a portion of 11 claims, involving 33 rejected services, for a total of $2,387. The claims, if they had been paid, would have been reimbursed at 80%, subject to an annual deductible of $50, for a total of $1,909.

Emma McGrew has also submitted two claims to Blue Cross. The first was for service on April 25, 1985; the total claim was $49. Blue Cross paid the claim, minus a $9.80 co-payment portion. The second was a claim for reimbursement of a number of prescription drug charges totaling $458.80. The claim was rejected because it had not first been filed with the primary carrier, WPS.

The McGrews filed a complaint in the circuit court for Milwaukee County, with claims against the defendants for breach of contract, misrepresentation, bad faith, tortious

interference with contract, "gross conduct" outside the scope of ERISA, breach of a fiduciary duty, and emotional distress. They seek contract damages in the amount of $50,000; other compensatory damages in the amount of $2,000,000; and punitive damages in the amount of $10,000,000, plus costs and disbursements. The action was removed to this court and the defendants have filed motions for dismissal of the action or for summary judgment.

Blue Cross has moved for summary judgment and for an order striking plaintiffs' jury demand. Blue Cross claims that plaintiffs' state law claims against it are preempted under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (ERISA). In addition, Blue Cross requests sanctions against plaintiffs, pursuant to rule 11 of the federal Rules of Civil Procedure, for the frivolous and excessive nature of the punitive damage claim.

WPS, joined by Milwaukee County, contends that it is entitled to summary judgment because (1) neither it nor the county received notice of the claims as required by § 893.80, Wisconsin Statutes; (2) as a matter of law, plaintiffs cannot maintain an ERISA action against WPS; (3) the compensatory damage request is excessive; and (4) the punitive damage request is frivolous.

First, to discuss the ERISA issues: Blue Cross claims that plaintiffs' state law claims are preempted by ERISA; WPS, joined by Milwaukee County, claims that no ERISA claim can be maintained against it. The defendants are correct.

ERISA provides that a participant in a plan may bring an action

> to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

The preemptive effect of ERISA is governed by 29 U.S.C. § 1144. Section 1144 (a) states that ERISA supersedes any state laws which relate to employee benefit plans described in section 1003(a). Section 1003(a) states that the law applies to benefit plans maintained by an employer or by an organization of employees. Also pertinent here, however, is section 1003(b) which states that the provisions do not apply to government plans. Thus the difference in the positions of WPS and Blue Cross. WPS administers a government plan; Blue Cross a private plan.

Other statutes also must be considered. Section 1144(b) (2) (A), known as the "savings" clause, states that nothing in the act "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." And section 1144 (b) (2) (B), known as the "deemer" clause, states that no plan described in section 1003 (a), which is where this saga began, shall be "deemed to be an insurance company..."

The effect of the savings clause and the deemer clause is that if a plan is self-insured, even if it is administered by an insurance company, ERISA preempts state law. The plan then is deemed not to fall under provisions applying to insurance companies and the savings clause does not apply. *See Moore v. Provident Life and Accident Insurance Company*, 786 F. 2d 922 (9th Cir. 1986); *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F. 2d. 416 (7th Cir. 1988). The result of the statutory scheme is that the claims against Blue Cross are preempted by ERISA, but no ERISA claim can be

brought against WPS or Milwaukee County.

Even if the state law claims against Blue Cross are preempted, there could be an argument that extracontractual damages are available under the language in 29 U.S.C. § 1132(a) (3) calling for "other appropriate equitable relief." However, as have the majority of the other circuits, the Court of Appeals for the Seventh Circuit has concluded that extracontractual damages are not available. *Pokratz v. Jones Dairy Farm*, 771 F. 2d 206 (7th Cir. 1985).

Plaintiffs' claim against Blue Cross, then, is a claim for benefits under ERISA. As stated above, two claims were submitted to Blue Cross. One was paid, except for the co-payment. The other, for $458.80, was rejected on the basis of the Coordination of Benefits clause. Blue Cross contends that it sent the McGrews an "Explanation of Benefits" form advising them to submit the claim to the primary carrier. Although it is not entirely clear, the McGrews may be contending that they never received the form. They do not, however, contest the existence of a valid coordination of benefits clause. At this time they also clearly have notice that Blue Cross has rejected the claim and the basis for that rejection. The lawsuit is not ripe. They should submit the claim to WPS and see what happens. If it is rejected by WPS, they can submit it to Blue Cross. If Blue Cross rejects it, perhaps an ERISA claim can be maintained. The ERISA claim against Blue Cross will be dismissed. Given this posture of the case, the punitive damage claim against Blue cross must also fall.

WPS argues that the claims against it (and Milwaukee County) must fail because plaintiffs did not file a notice of

claim as required by §893.80, Wisconsin Statutes.

A plaintiff need not allege in his complaint that he has complied with section 893.80, but the requirement of the statute must be satisfied before a suit can be brought against a government body or its agent. *Weiss v. City of Milwaukee,* 79 Wis. 2d 213 (1977). If a defendant raises the issue, a plaintiff has the burden of proving compliance with the statutory conditions. *Elkhorn Area School District v. East Troy Community School District*, 110 Wis. 2d 1 (Ct. App. 1982).

If a plaintiff has not filed a notice, then he may not proceed with the lawsuit unless he can prove that WPS or the county had actual notice of the claims and that the failure to give notice was not prejudicial.

The McGrews state that no notice is required against the county because no claim is made against the county except to the extent that contract benefits are due. They further contend that WPS is not entitled to notice. The argument is that the notice requirement applies only to the county and its agents. There is no evidence, they argue, of an agency relationship between WPS and the county; rather WPS is an independent contractor. The McGrews also claim that, in any case, the issue as to whether an agency relationship exists is a jury question.

The McGrews cite *Scheuer v. Central States Pension Fund,* 358 F. Supp. 1332 (E.D. Wis. 1973) for the proposition that it is a jury question as to whether an agency exists. In *Scheuer* it was a jury question; however, that is not always the case. In *Lofy v. Joint School district No. 2*, 42 Wis. 2d 253 (1969), the court upheld a decision granting summary judgment on the issue. The court analyzed the contract and

found that the entity in question was an independent contractor, not an agent.

Ordinarily, where a written contract exists, construction of the contract is a question of law for the court. *Koenings v. Joseph Schlitz Brewing Co.*, 126 Wis. 2d 349 (1985); *Streiff v. American Family Mutual Insurance Co.*, 118 Wis. 2d 602 (1984). Here a contract exists under which WPS administers the group plan. Section III(i) of the contract provides:

> WPS, in performing its obligations under this Agreement, is acting only as agent of the Group and shall not be designated or deemed the fiduciary with respect to the Plan under any federal or state law.

That provision alone would perhaps not be dispositive of the issue. However, other provisions of the contract support the contention that WPS is an agent.

In determining whether an agency relationship exists, the "most important single indicium is who has retained the right to control the details of the work." *Lofy, supra*, at 262, quoting *Madix v. Hochgreve Brewing Co.*, 154 Wis. 448 (1913). In this case, while WPS makes the initial determination as to the extent of benefits to be paid to any claimant, the county Group retains the right to have the final word. *See* section III (b). Further, the Group assumes all responsiblitity for state or federal laws which apply to the agreement. *See* section III (h). I find that WPS is an agent and is entitled to a notice of claim, under section 893.80.

As stated above, however, if WPS or the county had actual notice of the claims asserted in the complaint and if the failure to give statutory notice was not prejudicial, the action

can proceed. It seems clear here that WPS had actual notice of the contractual claim for payment of benefits. However, the McGrews make no attempt to show that WPS knew that it would be sued for $2,000,000 in compensatory damages, $50,000 in contract damages, and $10,000,000 in punitive damages. The contract claim for payment of benefits may proceed. The other claims are dismissed.

Even were there no agency relationship found here, WPS (as did Blue Cross) argues that the damages requested are far out of line with the benefits allegedly due. WPS states that in any case, the tort liability of a governmental body cannot exceed $50,000. § 893.80(3), Wisconsin Statutes. In regard to the request for punitive damages, both parties seek sanctions pursuant to rule 11 of the Federal Rules of Civil Procedure on the basis that the claim is frivolous.

The appropriate sanction, both contend, is dismissal of the punitive damage claim. As stated above, the claim is dismissed on other grounds; however, even if it had not been, I would dismiss it with prejudice as an appropriate sanction under rule 11.

Thus, I will, in an exercise of discretion, remand the remainder of the dispute to the state court, where it was originally filed. *See Carnegie-Mellon University v. Cohill*, 108 S. Ct. 614 (1988).

IT IS THEREFORE ORDERED that all claims in this lawsuit with the exception of a contract claim for benefits against WPS and Milwaukee County are DISMISSED.

IT IS FURTHER ORDERED that this action is remanded to the Circuit Court for Milwaukee County.

Dated at Milwaukee, Wisconsin this 7th day of October, 1988.

BY THE COURT:
/S/ Terence Evans
TERENCE T. EVANS
UNITED STATES DISTRICT JUDGE

JUDGMENT IN A CIVIL CASE

United States District Court	DISTRICT Eastern District of WI
CASE TITLE	
McGREW, EMMA, et al. V. WISCONSIN PHYSICIANS SERVICE CORP., et al.	DOCKET NUMBER 87-C-1224 NAME OF JUDGE Terence T. Evans

Decision by Court. This action came to trial or hearing before the Court with the judge named above presiding. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

That all claims in this lawsuit with the exception of a contract claim for benefits against WPS and Milwaukee County are DISMISSED.

It is further ordered that this action is remanded to the Circuit Court for Milwaukee County.

CLERK Sofron B. Nedilsky	DATE
(BY) DEPUTY CLERK /s/ Regina Torcivia	10/7/88

Civil Action No. 89-3523, no. 90-1378

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
1992 U.S. App. LEXIS 5497
February 14, 1991, Argued
March 27, 1992, Decided

JACKSON B. SMITH and VIVIAN E. SMITH,
Plaintiffs-Appellants,

v.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and DELCO ELECTRONICS CORPORATION,
Defendants-Appellees

JACKSON B. SMITH and VIVIAN E. SMITH,
Plaintiffs-Appellants,
and MARJAN R. KMIEC,
one of the Attorneys for Plaintiffs, Appellant,

v.

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and DELCO ELECTRONICS CORPORATION,
Defendants-Appellees.

PRIOR HISTORY: [*1] Appeal from the United States District Court for the Eastern District of Wisconsin. No. 89 C 473–Robert W. Warren, Judge.

DISPOSITION: AFFIRMED.

COUNSEL: For JACKSON B. SMITH, Plaintiff - Appellant: Marjan R. Kmiec, 414/649-9790, Christopher A. McConville, 414/649-9790, 3741 W. National Avenue, Milwaukee, WI 53215, USA. For VIVIAN E. SMITH, Plaintiff - Appellant: Marjan R. Kmiec, 414/649-9790, Christopher A. McConville, 414-649-9790, 3741 W. National Avenue, Milwaukee, WI 53215, USA.

For BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN, Defendant - Appellee: Kim M. Cafaro, 414/226-6925, Laurel Barnes, 414/226-6289, BLUE CROSS & BLUE SHIELD OF WISCONSIN, 401 W. Michigan Street, Milwaukee, WI 53201, USA. For DELCO ELECTRONICS, a General Motors Corporation, Defendant - Appellee: Susan R. Maisa, 414/271-2400, George D. Cunningham, 414/289-3577, FOLEY & LARDNER, 777 E. Wisconsin Avenue, Milwaukee, WI 53202, USA.

For MARJAN R. KMIEC, one of the attorneys for plaintiffs, Appellant: Christopher A. McConville, 414/649-9790, Marjan R. Kmiec, 414/649-9790, 3741 W. National Avenue, Milwaukee, WI 53215, USA.

For JACKSON B. SMITH, Plaintiff - Appellant: Marjan R. Kmiec, 414/649-9790, Christopher A. McConville, 414/649-9790, [*2] 3741 W. National Avenue, Milwaukee, WI 53215, USA. For VIVIAN E. SMITH, Plaintiff - Appellant: Marjan R. Kmiec, 414/649-9790, Christopher A. McConville, 414/649-9790, 3741 W. National Avenue, Milwaukee, WI 53215, USA.

For BLUE CROSS & BLUE SHIELD UNITED OF

WISCONSIN, Defendant - Appellee: Kim M. Cafaro, 414/226-6925, Laurel Barnes, 414/226-6289, BLUE CROSS & BLUE SHIELD OF WISCONSIN, 401 W. Michigan Street, Milwaukee, WI 53201, USA. For DELCO ELECTRONICS, a General Motors Corporation, Defendant - Appellee: Susan R. Maisa, 414/271-2400, George D. Cunningham, 414/289-3577, FOLEY & LARDNER, 777 E. Wisconsin Avenue, Milwaukee, WI 53202, USA.

JUDGES: Before WOOD, JR. n1 and POSNER, Circuit Judges, and FAIRCHILD, Senior Circuit Judge.

n1 Judge Wood, Jr., assumed senior status January 16, 1992, after oral argument of this case.

OPINION BY: FAIRCHILD

OPINION: FAIRCHILD, Senior Circuit Judge. In March 1989, the Smiths filed a complaint against Delco Electronics and Blue Cross and Blue Shield in a Wisconsin court. The complaint alleged that Mr. Smith was employed by Delco Electronics and that he and his wife were beneficiaries of Delco's group insurance plan, which was insured by Blue Cross. It alleged in an [*3] introductory portion that the plan provided remedies both under the Employment Retirement Income Security act of 1974 (ERISA), 29 U.S.C. § 1001 et seq. and state law. Because of Mr. Smith's arthritis and Mrs. Smith's diabetes, they undertook a weight loss program under medical supervision and submitted the bills to Blue Cross for payment. On August 20, 1987, Blue Cross denied the Smiths' claims. Although the complaint asserted plaintiffs' entitlement to ERISA remedies, it set forth as separate claims for relief state law claims that the denial was a breach of contract, was done in bad faith, that the denial was a

breach of fiduciary duty, caused emotional distress, and deprived them of constitutional rights to life, liberty and property.

Delco and Blue Cross removed the case to federal court on the ground that the action arose under the constitution and laws of the United States, including ERISA. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (exception to well-pleaded complaint rule when ERISA preemption is a defense). Delco and Blue Cross then moved to dismiss the case on grounds that the state causes of action were preempted by ERISA and that [*4] the constitutional claims could be based only on actions by government entities. In the alternative, they moved for summary judgment on the ground that if the complaint be construed as an ERISA claim for benefits, it must be dismissed because the Smiths did not exhaust their internal remedies under the plan. Delco and Blue Cross also moved for sanctions pursuant to Rule 11 of the Federal Rules of Civil Procedure. The district court dismissed the action and imposed sanctions against the plaintiffs' attorneys, awarding defendants their costs and reasonable attorneys' fees. *Smith v. Blue Cross & Blue Shield United of Wisconsin*, 724 F. Supp. 618 (E.D. Wis. 1989). Delco and Blue Cross requested fees and costs of $17,244.32, and the district court awarded $12,874.32. The Smiths and Mr. Kmiec, one of their attorneys, have appealed. The issues before us are whether the Smiths' state law claims are preempted by ERISA, whether they exhausted their internal remedies under the plan, and whether the court erred by awarding sanctions.

ERISA PREEMPTION

ERISA preempts all state laws which "relate to any employee benefit plan," 29 U.S.C. § 1144 (a) (preemption clause), unless [*5] the state law "regulates insurance, banking, or securities," 29 U.S.C. § 1144 (b) (2) (A) (saving clause). However, self-funded plans are exempt from state laws that regulate insurance. 29 U.S.C. § 1144 (b) (2) (B) (deemer clause); *FMC Corp. v. Holliday*, 111 S. Ct. 403, 409 (1990). The Supreme Court has held that ERISA preempts state common law tort and contract actions, including bad faith claims, "asserting improper processing of a claim for benefits under an ERISA-regulated plan." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987). In *Pilot Life*, the Court said that the bad faith common law cause of action asserted there relates to an employee benefit plan. The cause of action therefore comes under the preemption clause, and is not saved because the state (Mississippi) law of bad faith does not regulate insurance.

Although the Smiths' state common law tort and contract claims are the same as those brought by the plaintiffs in *Pilot Life*, the Smiths argue that *Pilot Life* does not apply to Wisconsin's bad faith common law. They argue that in *Pilot Life*, the Court considered Mississippi's law of bad faith, and that Mississippi's [*6] law applies generally while Wisconsin's law of bad faith is applied only to insurance contracts. That distinction cannot be maintained. In *Pilot Life*, the Court said,

Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for

punitive damages under Mississippi law.

Id. at 50. Wisconsin's law of bad faith is similarly "planted in the general principles of [Wisconsin] tort and contract law." In *Anderson v. Continental Ins. Co.*, 271 N.W. 2d 368, 371 (Wis. 1978), the Wisconsin Supreme Court recognized "a cause of action in tort against an insurer for the bad faith refusal to honor a claim of the insured." The court analyzed the bad faith action as a typical tort case:

By virtue of the relationship between the parties created by the contract, a special duty arises, the breach of which duty is a tort and is unrelated to contract damages. This tort of bad faith or malicious and intentional harassment [*7] by one party to a contract directed toward the other party,who seeks to assert his contract claim, has been referred to as a "tortious breach of contract."

Id. at 374. The court also relied on standard contract principles: "'Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.'" Id. at 375 (quoting Restatement of Contracts, Second, § 231 (tentative drafts Nos. 1-7, rev. and edited, 1973)). Thus, under *Pilot Life* the Smiths' claims are clearly preempted by ERISA. This court has found preemption of the same and comparable state law causes of action in two cases decided since oral argument of the Smiths' appeal. *Tomczyk v. Blue Cross & Blue Shield*, 951 F. 2d 771, 775 (7th Cir. 1991); *Maciosek v. Blue Cross & Blue Shield*, 930 F. 2d 536, 538-40 (7th Cir. 1991). Attorneys for the plaintiff were the same in all three cases.

The Smiths argue that even if their claims are preempted by ERISA, ERISA applies only to plan fiduciaries, and there

is no evidence that Delco and Blue Cross are both fiduciaries. The Smiths, however, have waived this claim [*8] because they presented it for the first time on appeal. *Maciosek*, 930 F. 2d at 540 n. 2. Moreover, in their complaint, the Smiths alleged, "the defendants have various fiduciary duties to the plaintiffs."

EXHAUSTION

The Smiths next argue that even if state law claims are preempted, their complaint also asserts claims under ERISA. The complaint sets forth as separate claims for relief only state law causes of action, and the claim alleging deprivation of constitutional rights. The complaint, in describing the employee benefit plan, says the plan provides remedies under both state law and under ERISA. The complaint would not ordinarily be treated as sufficient pleading of a claim under ERISA. This court has recently considered whether a complaint filed by the same lawyer representing the Smiths could be construed to include ERISA claims. The court held,

Their decision here to file only state claims in state court, thereby ignoring ERISA, can only be seen as a strategic attempt to avoid removal to federal court. The [plaintiffs] never sought to amend their complaint to add ERISA counts, even after their strategy failed and the case was removed to federal court. [*9] They are bound by those decisions.

Maciosek, 930 F. 2d at 540-41. See, however, *Bartholet v. Reischauer*, slip op. No. 90-2671 (7th Cir., Jan. 15, 1992) holding that a pleading which gives sufficient notice of a claim showing that the pleader is entitled to relief under ERISA should not be dismissed for failure expressly to invoke ERISA.

Even construing the complaint as stating an ERISA claim, we affirm. The district court wrote that summary judgment would then be appropriate because plaintiffs had not exhausted their internal plan remedies. *Smith*, 724 F. Supp. at 622. A district judge may so decide, and we would disturb this decision only if there has been a clear abuse of discretion. *Powell v. A.T. & T. Communications, Inc.*, 938 F. 2d 823, 925 (7th Cir. 1991); *Kross v. Western Electric Co.*, 701 F. 2d 1238, 1244 (7th Cir. 1983). Judgment on this theory will not prevent plaintiffs from exhausting their plan remedy, assuming they are not barred by lapse of time, and then suing upon the merits.

The Smiths argue that requiring exhaustion would be an abuse of discretion because although they did not exhaust [*10] their internal plan remedies, n2 two exceptions to the exhaustion requirement apply to them. First, the Smiths claim the futility exception applies to their claims, although they do not explain why an appeal would be futile. In order to come under the futility exception, the Smiths must show that it is certain that their claim will be denied on appeal, not merely that they doubt an appeal will result in a different decision. *Dale v. Chicago Tribune Co.*, 797 F. 2d 458, 467 (7th Cir. 1986) ("absence of 'neutral arbitrator' does not, by itself, render the exhaustion of such procedures futile"), cert. denied, 479 U.S. 1066 (1987); *Carter v. Signode Industries, Inc.*, 688 F. Supp. 1283, 1287 (N.D. Ill. 1988) (exhaustion was futile where putative class members had appealed decision and the Director of the Plan "made it clear that no adjustments were forthcoming"). Because the Smiths have represented no facts to show that the review procedures would not work, the futility exception does not apply.

– – – – – – – – Footnotes – – – – – – – –

n2 In their complaint, the Smiths allege that they exhausted their internal remedies, but in their brief they seem to concede that they did not, and an affidavit by Delco's supervisor of benefit plan administration states they did not. Although the Smiths could appeal the claims by merely notifying their local union benefit representative that their claims had been wrongly denied, they did not do so. In his affidavit, Mr. Smith said he contacted his union benefit representative four times, but he said these contacts occurred in 1986, and his claims were not denied until August 20, 1987. The appellate procedure clearly requires that the claimant contact the union benefit representative after the denial of the claim.

– – – – – – – – End Footnotes – – – – – – – –

[*11]

The second exception to the exhaustion requirement is that claimants are not required to appeal when there is a lack of meaningful access to the review procedures. *Carter*, 688 F. Supp. at 1287-88 (there is a lack of meaningful access if claimant attempts to initiate higher levels of review procedure, but a party has denied claimant access to higher levels of review); *Boesl v. Suburban Trust & Sav. Bank*, 642 F. Supp. 1503, 1516 (N.D. Ill. 1986) (claimant denied meaningful access because he was not told how to file appeal or told review procedure was available). The Smiths claim they were denied access because, subsequent to the denial of their benefits, they repeatedly requested review, but received no response. There is, however, no support in the record for this assertion. In his affidavit, Mr. Smith says that he asked

his union benefit representative to request review and that his lawyer wrote to Blue Cross to request review. These requests, however, occurred in 1985 and 1986, and the Smiths' claim was not denied until August 20, 1987. At oral argument, the Smiths claimed for the first time that they could not appeal because they had never [*12] been informed of the review procedures, despite having requested a plan booklet several times. Not only is there no evidence in the record that the Smiths were unaware of the review procedures, but the Smiths waived this argument by failure to raise it before the district court.

SANCTIONS

The Smiths' lawyer, Mr. Kmiec, has appealed both the decision to award attorneys' fees under Rule 11 and the amount of the fee award. The district judge explained the basis for his award of sanctions: n3

This action encompasses a classic violation of Rule 11. No reasonable attorney having read *Pilot Life* and *Taylor* could manufacture a good faith argument as to why this suit should be brought. Further, any attorney making a "a reasonable inquiry" would have come across *Pilot Life* and *Taylor*. This case is contrary to settled precedent, and falls directly into the *Eastway Construction [Corp. v. City of New York*, 762 F. 2d 243, 254 (2d Cir. 1985),] definition of having no chance of success under existing precedent. That defense counsel alerted plaintiffs' counsel of the frivolity of the claim and pointed the attorneys to the directly contrary precedent only exacerbates [*13] the unreasonableness of plaintiffs' counsels' actions.

Smith, 724 F. Supp. at 623.

– – – – – – – – Footnotes – – – – – – – –

n3 Counsel's signing the compliant was not a violation of Rule 11, subject to sanctions, because the complaint was filed in state court. *Schoenberger v. Oselka,* 909 F. 2d 1086, 1087 (7th Cir. 1990). Although the district judge primarily addressed the frivolousness of the complaint, he also referred to the "arguments plaintiffs' counsel advances" and to counsel's ignoring the relevant precedent after removal to federal court, doubtless covering the frivolousness of plaintiffs' brief in opposition to the motion to dismiss. The brief was filed after removal and was a proper predicate for sanctions under Rule 11. Id., *Maciosek*, 930 F. 2d at 541-42.

– – – – – – – –End Footnotes – – – – – – – –

We must defer to the district judge's decision to award sanctions and reverse only if he abused his discretion. *Cooter & Gell v. Hartmarx Corp.*, 110 S. Ct. 2447, 2461 (1990). We agree with the district court. Mr. Kmiec's [*14] constitutional arguments and preemption arguments in the response to the motion to dismiss were frivolous. Happily he does not repeat the constitutional arguments on appeal.

Constitutional claims clearly cannot be brought against insurance companies merely because they are subject to extensive state regulation. A year before Mr. Kmiec filed the Smiths' complaint, the Eastern District of Wisconsin forcefully rejected a similar claim brought by Mr. Kmiec, *Koller v. Aetna Life Ins. Co.*, 717 F. Supp. 648 (E.D. Wis. 1988).

The above discussion of preemption adequately supports the finding that the Smiths' preemption argument was

frivolous. Furthermore, Mr. Kmiec did not mention *Pilot Life* in his brief in opposition to the defendants' motion to dismiss, let alone make a good faith argument for a modification or reversal of *Pilot Life*. Mr. Kmiec cannot argue that he was not aware of the weaknesses in his arguments or that a reasonable person would not have been aware of the weaknesses. Before the defendants filed their motion to dismiss, Delco's counsel wrote to Mr. Kmiec and advised him that his claims were frivolous and referred him to the applicable law. Delco's [*15] counsel warned that if Mr. Kmiec did not voluntarily dismiss the complaint, or at least amend the complaint to include only ERISA claims, she would request Rule 11 sanctions. Significantly, another panel of this court has recently upheld Rule 11 sanctions against Mr. Kmiec for bringing frivolous state common law claims that were preempted by ERISA. *Maciosek*, 930 F. 2d at 542. In a similar case, this court has imposed sanctions on Mr. Kmiec and his associate, Mr. McConville, finding the appeal frivolous. *Tomczyk v. Blue Cross & Blue Shield*, 951 F. 2d 771, 777-79 (7th Cir. 1991).

AMOUNTS AWARDED

Foley & Lardner, attorneys for Delco, submitted an affidavit of costs and attorney's fees totalling $8,979.32. Blue Cross and Blue Shield's in-house counsel submitted an affidavit of costs and attorney's fees totalling $8,265.00.

Mr. Kmiec filed lengthy objections, a substantial part of which reargued the question whether the award of any sanctions was appropriate. He did address many of the items claimed by defendants, in some instances stating an objection, and in some merely reciting what the charge had

been.

Judge Warren wrote a decision in which [*16] he fairly summarized the objections under 12 headings, and then dealt with them. As to arguments (1) - (3) (inappropriateness of charging for strategy sessions and general conferences between defendants), Judge Warren found them "partially persuasive" and said he applied the conclusions to disputed billings. As to argument (4), (a particular Blue Cross brief with routine citations does not merit the time billed), Judge Warren agreed and reduced the billing by half to $375.00. As to argument (5), (19.9 hours of phone conferences excessive), Judge Warren agreed and reduced by half to $995.00. As to argument (6), (excessiveness of 8 hours for an affidavit), he agreed and reduced by three-quarters, to $100.00. As to argument (8), (challenge to charge for 4.8 hours spent by senior counsel at $205.00 per hour), Judge Warren disagreed, saying that as long as the billings are reasonable, plaintiffs cannot complain that Delco chose expensive counsel. As to argument (9), (excessiveness of combined billing rate for strategy conferences), Judge Warren agreed and reduced the item by $700.00. As to argument (10), (similar to (9)), he agreed and reduced the amount by $800.00. As to argument [*17] (11), (similar to (9)), Judge Warren agreed and reduced the amount by $400.00. As to argument (12), (similar to (9)), he agreed and reduced the total by $500.00. The court awarded $6,579.32 to Delco and $6,295.00 to Blue Cross.

Mr. Kmiec did include in his statement to the district court the assertion that plaintiffs would have voluntarily dismissed the action against Delco if Delco counsel had notified him that the plan was insured. Delco counsel asserted that she could not so represent because Delco (for

some reason), wished to preserve its position that its plan was self-insured. In this court, Mr. Kmiec argues that Delco counsel failed to mitigate attorney's fees by informing him that the plan was insured, although he did not refer to a duty to mitigate in his objections in the district court.

We are not aware of Mr. Kmiec's reason for believing that he needed both defendants in the case, and why it made any difference in the outcome whether the arrangement between Blue Cross and Delco produced an insured plan or a self-insured plan. And Mr. Kmiec should have dismissed as to both defendants after the controlling authority was pointed out to him. We owe deference to the district [*18] court's computation of fees, *Cooter & Gell*, 110 S. Ct. at 2458. Judge Warren carefully considered the objections and made substantial reductions. There was no abuse of discretion.

SANCTIONS ON APPEAL

Delco and Blue Cross request that we also impose sanctions under Rule 38 of the Federal Rules of Appellate Procedure on the ground that Mr. Kmiec pursued a frivolous appeal. Sanctions are appropriate if "the appeal was prosecuted with no reasonable expectation of altering the district court's judgment and for purposes of delay or harassment or sheer obstinacy." *Reid v. United States*, 715 F. 2d 1148, 1155 (7th Cir. 1983). Although in *Maciosek*, 930 F. 2d at 542, this court decided not to award Rule 38 sanctions against Mr. Kmiec for his argument that ERISA did not preempt state common law claims, this case is distinguishable from *Maciosek*.

In this case, not only were the preemption arguments frivolous, but also the arguments concerning exhaustion of

internal plan remedies had no basis in fact. In *Maciosek*, Mr. Kmiec argued that breach of contract and tortious interference with contract claims were not preempted by ERISA, [*19] and this court recognized that it had not addressed whether ERISA preempted those specific issues. In this case, however, Mr. Kmiec argued that a bad faith claim was not preempted, although the Supreme Court considered Mississippi and not Wisconsin bad faith common law, Mr. Kmiec's attempt to distinguish the laws of the two states was frivolous. His only support for the distinction was a Wisconsin case which held that a duty of good faith does not apply to the termination of a terminable at will employee. *Brockmeyer v. Dun & Bradstreet*, 335 N.W. 2d 834, 838 (Wis. 1983). Mr. Kmiec made no attempt to prove that Wisconsin bad faith law, unlike Mississippi bad faith law, was not based on principles of tort and contract.

Mr. Kmiec's argument that the Smiths should be excused from exhausting their internal remedies was frivolous because no evidence supports this argument. At oral argument, Mr. McConville, Mr. Kmiec's associate, argued that the Smiths could not exhaust their remedies because they had not received a plan booklet which informed them what their remedies were. There is, however, [*20] no evidence that the Smiths did not have information about how to appeal the denial of their claims, and this argument was not made until the oral argument to this court. Furthermore, at oral argument, Mr. McConville seemed to claim that he still did not have a description of the review procedures, although a description of the procedure was part of the record, and the appellees included the description in a short appendix to their brief. Mr. McConville also argued that the Smiths had attempted to appeal but had received no response. All of the

communications shown in the record, however, clearly occurred before the claim was denied.

The combination of frivolous legal arguments with regard to preemption and frivolous factual arguments with regard to exhaustion appear to warrant the imposition of sanctions on Mr. Kmiec pursuant to Fed. R. App. P. 38. No reasonable attorney could have thought that this court would overturn the decision of the district court, and Mr. Kmiec's arguments are "sheer obstinacy." In conformance with Circuit Rule 38, this opinion will serve as notice to Mr. Kmiec that the court is contemplating sanctions, and we will allow him 14 days to submit a statement as [*21] to why sanctions should not be imposed in accordance with this opinion.

Accordingly, the decision of the district court is AFFIRMED.